1.0 Description of the Service

The purpose of case management services for adults and children at-risk for abuse, neglect or exploitation is to assist them in gaining access to needed medical, social, educational, and other services; to encourage the use of cost-effective medical care by referrals to appropriate providers; and to discourage over-utilization of costly services.

2.0 Eligible Recipients

2.1 General Provisions

1. Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.
2. Medicaid-eligible adults and children of all ages, who have been assessed by an enrolled At-Risk Case Management Service provider and meet the criteria listed in **Section 3.0** are eligible for this service.
3. Non-waiver clients are eligible for At-Risk Targeted Case Management services if they meet the criteria listed in **Section 3.0.**

2.2 Special Provisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition identified through a screening examination. While there is no requirement that the service, product or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. § 1396d(a). Service limitations on scope, amount or frequency described in this coverage policy do not apply if the product, service or procedure is medically necessary.

The Division of Medical Assistance's policy instructions pertaining to EPSDT are available online at http://www.dhhs.state.nc.us/dma/prov.htm.

2.3 Recipients with Medicaid for Pregnant Women Coverage

Recipients with Medicaid for Pregnant Women (MPW) (pink Medicaid card) are covered only by the Medicaid MPW policy.

2.4 Child Services Coordination

Recipients who are covered by Medicaid for child services coordination only are not eligible for this service.

2.5 Medicare Qualified Beneficiaries

Medicare Qualified Beneficiaries (buff Medicaid card) are only covered for services when the service is covered by Medicare.

3.0 When the Service is Covered

3.1 General Criteria

Medicaid covers At-Risk Case Management Services when:

1. The assessment has been performed by a provider who is certified by the N.C. Division of Aging and Adult Services and is enrolled with Medicaid as a case management provider.
2. The service is medically necessary. (When the individual meets Medicaid requirements and meets one or more of the adult or child categories, the service is considered to meet the medical necessity requirement for At Risk Case Management Services.)
3. The service furnished has no equally effective, more conservative or less costly treatment available statewide.
4. The service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker or the provider.

3.2 Adults

An at-risk adult is an individual who is at least 18 years old, or an emancipated minor, is not institutionalized, and meets one or more of the following criteria:

1. an adult with only one consistent identified caregiver, who needs personal assistance 24 hours per day with two or more of the activities of daily living (bathing, dressing, grooming, toileting, transferring, ambulating, eating communicating); **or**
2. an adult with no consistent identified caregiver, who is unable to perform at least one of the activities of daily living (bathing, dressing, grooming, toileting, transferring, ambulating, eating, communicating); **or**
3. an adult with no consistent identified caregiver, who is unable to carry out instrumental activities of daily living (managing financial affairs, shopping, housekeeping, laundry, meal preparation, using transportation, using a telephone, reading, writing); **or**
4. an adult who was previously abused, neglected or exploited and the conditions leading to the previous incident continue to exist.
5. an adult where abuse, neglect or exploitation has been confirmed and the need for adult protective services exists.

3.3 Children

An at-risk child is an individual under 18 years of age, is not institutionalized, and meets one or more of the following criteria:

1. a child with a chronic or severe physical or mental condition whose parent(s) or caretaker(s) are unable or unwilling to meet the child's care needs and who is not receiving targeted case management for the mentally retarded/developmentally disabled; **or**
2. a child whose parents are mentally or physically impaired to the extent that there is a need for assistance with maintaining family stability and preventing or remedying problems which may result in abuse or neglect of the child; **or**
3. a child born of adolescent parents (under age 18) or of parents who had their first child when either parent was an adolescent and there is a need for assistance with maintaining family stability, strengthening individual support systems, and preventing or remedying problems which may result in abuse or neglect of the child; **or**

4. a child who was previously abused, neglected or exploited and the conditions leading to the previous incident continue to exist; **or**
5. a child where abuse, neglect or exploitation has been confirmed and the need for child protective services exists.

4.0 When the Service is Not Covered

4.1 General Criteria

At-Risk Case Management Services are not covered when:

1. The recipient does not meet the eligibility requirements listed in **Section 2.0**.
2. The recipient does not meet the medical necessity criteria listed in **Section 3.0**. (The recipient does not meet one of the adult or child categories of eligibility for At-Risk Case Management Services.)
3. The service is experimental or investigational.
4. The recipient receives Medicaid case management services through the following sources or programs:
   a. recipients are hospitalized, institutionalized or in a nursing facility; **or**
   b. all Community Alternatives Programs (CAP); Child Services Coordination program (CSC); Maternity Care Coordination (MCC) program; Human Immunodeficiency Virus (HIV) Case Management Services.

4.2 Non-covered Services

Medicaid does not reimburse the Case Manager for:

1. time spent traveling to and from the recipient's location or for transporting a recipient to and from providers and programs for services
2. time spent in preparing documentation – completing the assessment form, writing the service plan, and the dictation and documentation activities for recipient records when these activities are performed as separate activities
3. the actual cost of services and resources, such as housing or counseling, as part of At-Risk Case Management Services

Note: Only the case manager's activities in assisting recipients to locate and utilize such resources are a reimbursable service.

4.3 Foster Care Program

If a child is in the legal custody or placement responsibility of a county DSS any activities performed by the foster care case worker that relate directly to the provision of foster care services cannot be covered as targeted case management. Since these activities are a component of the overall foster care service to which the child has been referred, the activities do not qualify as targeted Case Management Services for Adults and Children At-Risk for Abuse, Neglect or Exploitation. The following activities are considered to be part of the direct delivery of foster care services and, therefore, may not be billed to Medicaid as a case management activity:

1. research gathering and completion of documentation required by the foster care program
2. assessing adoption placements
3. recruiting or interviewing potential foster care parents
4. serving legal papers
5. home investigations

6. providing transportation
7. administering foster care subsidies and making placement arrangements

Note: This list is intended to be illustrative and is not all inclusive.

5.0 Requirements for and Limitations on Coverage

5.1 Service Components

5.1.1 Assessment

The individual's situation is evaluated to determine the need for initial or continuing At-Risk Case Management services. This component includes activities that focus on needs identification. Activities include assessment of an eligible individual to determine the need for any medical, educational, social and other services. Local county departments of social services (DSS) child welfare services staff use Structured Decision-Making Tools or the Child/Client/Family Assessment Form. DSS adult services staff uses the Adult Services Functional Assessment. DSS adult services staff uses the Adult Services Functional Assessment. The continuing appropriateness of providing At-Risk Case Management Services is assessed by the social worker during quarterly reviews of the service plan.

5.1.2 Service Planning

Service planning is a crucial component of providing At-Risk Case Management Services. The social worker may use the following forms to document service planning for the individual:

- a Child Client/Family Assessment Form and Service Plan; **or**
- the Adult Client/Family Assessment Form and Service Plan; **or**
- the DSS Family Services Agreement (DSS Children's Services form); **or**
- the Adult and Family Service Plan (Aging and Adult Services form)

Any one of these forms may be used to develop and implement the service needs of the individual. The Service Plan builds on the information collected through the assessment phase and includes activities to ensure the active participation of the Medicaid eligible individual and others to develop individual goals and a course of action. The goals and actions in the service plan should address medical, social, educational and other services needed by the Medicaid eligible individual. The Service Plan must be signed by the social worker and the recipient. Whichever form is used, the Service Plan must be reviewed quarterly to assess the continuing appropriateness of providing At-Risk Case Management Services. Quarterly visits must be conducted in a face to face contact between the social worker and the recipient.

5.1.3 Referral/Linkage

This component includes assisting the Medicaid eligible individual in locating and contacting medical, social, educational providers and/or programs and other services to meet the assessed needs of the individual. Service delivery is coordinated when multiple providers or programs are involved in care provision to assure the most appropriate services are rendered while avoiding duplication.

5.1.4 Monitoring/Follow-up

This component includes activities and contacts that are necessary to ensure the Service Plan is effectively implemented and adequately addresses the needs of the Medicaid eligible individual and is consistent with quality of care. The activities and contacts may involve the Medicaid eligible individual, family members, providers or other entities. This function includes making necessary adjustments in the Service Plan or Services Agreement and service arrangements with providers.

5.2 Provision of Services

Case managers are responsible for:

1. Obtaining referrals and conducting pre-screening assessments.
2. Verifying the recipient's Medicaid eligibility and determining any third party insurance coverage.
3. Identifying any other case management services the recipient may be receiving to ensure non-duplication of payment.
4. Assessing appropriateness of service and documenting service on the appropriate service plan or services agreement.
5. Resolving questions and completing forms with information from the contacting client, family, physician, and other appropriate personnel.
6. Performing a new assessment and creating a new service plan beyond the twelve month period. These activities must be completed during the 12th month of service. The service plan must be signed by the case manager and the recipient before services are provided beyond the initial 12 continuous months.

5.3 Location of Services

Services can be provided in any setting except public correctional or detention facilities and institutions.

5.4 Prior Approval

Prior approval is not required.

5.5 Limitations

Medicaid allows a maximum of 96 units per day/per recipient (96 units constitutes one day of case management activities).

6.0 Providers Eligible to Bill for the Service

6.1 Provider Certification

An agency certified and qualified by the N.C. Division of Aging and Adult Services may enroll with Medicaid as an At-Risk Case Management Services provider**.** A Medicaid-enrolled DSS may provide At-Risk Case Management Services.

6.2 Provider Agreement

All case management providers must sign a provider agreement with the Division of Medical Assistance (DMA) and meet all applicable state and federal laws governing the participation of providers in the Medicaid program.

6.3 Provider Agency Qualifications

6.3.1 Provider agencies for At Risk Case Management Services must meet the following qualifications:

1. Certified by the N.C. Division of Aging and Adult Services as a qualified case management provider.
2. Have qualified case managers with supervision provided by a supervisor who meets North Carolina state requirements for Social Work Supervisor I or Social Work Supervisor II classification.
3. Have the capability to access multi-disciplinary staff, when needed.
    a. For adults, this includes, at a minimum, medical professionals as needed and an adult protective services social worker meeting the qualifications in Subparagraphs (d)(1)(A)(i) and (d)(1)(A)(ii) of this Rule in the North Carolina Administrative Code, 22O.0124.
    b. For children, this must include medical professionals as needed and a child protective services social worker meeting the qualifications in Subparagraphs (d)(1)(B)(i) and (d)(1)(B)(ii)of this Rule in the North Carolina Administrative Code, 22O.0124.
4. Have experience as a legal guardian of persons and property.

6.3.2 Case Managers for Adults

Case Managers for at-risk adults must:

1. have a Master of Social Work degree or a Bachelor of Social Work degree, or be a social worker who meets North Carolina state requirements for Social Worker II classification; and
2. have training in recognizing risk factors related to abuse, neglect, or exploitation of elderly or disabled adults and in assessment of functional capacity and needs related to activities of daily living; and
3. have experience in case management services for elderly and disabled adults.

6.3.3 Case Managers for Children

Case Manager qualifications for at-risk children must:

1. Have a Master of Social Work degree or a Bachelor of Social Work degree, or be a social worker who meets State requirements for Social Worker II classification; and
2. Have training in recognizing risk factors related to abuse, neglect or exploitation of children and in assessing family functioning; and
3. Have experience in case management services for children and their families.

7.0 Additional Requirements

7.1 Case Manager Responsibilities

Case manager responsibilities include, but are not limited to, the following:

1. assessment, as described in **Section 5.1.1**;
2. service planning, as described in **Section 5.1.2**;
3. referral and linkage, as described in **Section 5.1.3**;
4. monitoring/follow-up, as described in **Section 5.1.4**;
5. communicating the goals of the service plan to the provider agency; and
6. reviewing the service plan quarterly and/or when there is a change in the recipient's condition.

7.1.1 Documentation Requirements

The following documents must be kept for a minimum of five years from the date of service and must be available to DMA or it's agent upon request. The records must include the following:

1. the recipient's name and date of birth on each page of the service record
2. assessment and service plans;
3. documentation of the case manager's At-Risk Case Management Service activities including:
   a. descriptions of at-risk case management service activities;
   b. dates of service;
   c. amount of time involved in at-risk case management service activities, in minutes;
   d. records of referrals to providers and programs;
   e. records of service monitoring evaluations;
   f. signatures and credentials of the person providing each service; and
   g. progress notes with achievements or measurable progress; description of services performed; the place of service delivery; and dates of service.

7.1.2 Provider Records

Each provider must maintain case records that indicate all contacts with and on behalf of recipients. Each provider must allow DMA to access the following documentation for each individual:

1. The recipient's name and Medicaid identification number.
2. A copy of the service plan with clearly defined goals and within timeframes.
3. Each event must be documented following the guidelines listed in item #2 of **Section 7.1.1**.

7.2 Quality Assurance

Providers must develop, implement and maintain a quality assurance plan and policy.

7.3 Non-duplication of Service

The provider must ensure that services do not duplicate the services of any other provider.

8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 2000

Revision Information:

Date	Section Revised	Change
12/1/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.
12/1/05	Section 5.1.1	The Adult Comprehensive Functional Assessment was corrected to the Adult Services Functional Assessment and text was added to indicated that the social worker conducts the assessment.
12/1/05	Section 5.1.2	Text was added to indicate that the Service Plan must be signed by the social worker and the recipient and that quarterly visits must be conducted face-to-face between the social worker and the recipient.

Attachment A: Claims Related Information

Reimbursement requires compliance with all Medicaid guidelines including obtaining appropriate referrals for recipients enrolled in the Medicaid Managed Care programs.

A. Claim Type

Providers bill for services using CMS-1500 claim form.

Note: Claims for services can be billed only if the case management activities are documented on the service plan and provided by qualified professionals. According to DMA Administrative Letter number 04-01 dated August 21, 2000, it is allowable for area mental health centers to bill for clinical case management and for DSSs to bill for at risk case management for the same day of service. Children's Developmental Service Agencies bill for targeted case management for at-risk children in the early intervention programs.

B. Third Party Liability

The availability of payment from other sources must be taken into account prior to expending Medicaid funds. Each provider must develop a billing system to identify and bill all liable third parties.

C. Diagnosis Code(s)

Providers must bill the most relevant ICD-9-CM diagnosis code.

D. Procedure Code(s)

Case Management Services for Adults and Children At-Risk for Abuse, Neglect or Exploitation are billed with HCPCS procedure code T1017, Targeted Case Management, for each 15 minute unit.

E. Modifiers

Procedure code T1017 has no modifier for Case Management Services for Adults and Children At-Risk for Abuse, Neglect or Exploitation.

F. Providers must bill usual and customary charges. There will be a cost settlement at the end of the state fiscal year to adjust payments to equal the cost of the service.

G. Units of Service

At-Risk Case Management Services is reimbursed in units of services (15 minutes = 1 unit). The daily time spent by the case manager performing case management activities for a recipient may be totaled and converted to the appropriate unit of service (15 minutes) and billed as one charge to Medicaid.

H. Limitations

Medicaid allows a maximum of 96 units per day/per recipient (96 units constitutes one day).

I. Place of Service

Services can be provided in any setting except public correctional or detention facilities and institutions.